



MEDICAL THERAPY SERVICES COST SHARE APPLICATION

Applicants are under no obligation to provide the following information; however, incomplete applications may result in delay or a denial of the application. Information is collected and stored under the rules set forth by the Minnesota Data Privacy Act.

NAME (Last) Phone #	(First)	(Middle)	Date of Birth	Home
Address (Street) (County)	(City)	(State)	(Zip)	
Place of Employment Number	Address		Telephone	

FAMILY MEMBERS IN HOUSEHOLD or dependent upon family income:

Name	Date of Birth	Relationship	Occupation

Present Family Financial Situation:

Family's gross income (before taxes or withholding).

Current monthly _____

Expected Annual _____

Other income (rental income, tips, jury duty, severance pay, royalties and honoraria, alimony, annuity, pension payments, worker's comp. etc.) _____

1. Present value of savings accounts & cash _____

2. Value of stocks and bonds _____

*****Include copies for proof of income/financial status; see cover letter for requirements**

(See next page for Signatures and Assurances.)

Signatures and Assurances

I understand that:

- 1 The information in this summary is private and will not be released outside of Courage Center without my express consent.
- 2 All statements made on this summary are true and correct to the best of my ability. Any falsified statements will result in immediate termination of the cost share program.
- 3 It is my responsibility to notify Courage Center of changes in income or family status during the period of eligibility.

Signature (relationship if not signed by client)
Application

Date of

Mail Completed Application to:
Courage Center
Patient Account Services
3915 GoldenValley Road
Golden Valley, MN 55422